

prescribe cerium oxalate in too small doses, 2 to 3 grains. Since it appears that cerium oxalate accomplishes its purpose by mechanically coating the walls of the stomach they advise the administration of cerium oxalate in doses comparable to those in which bismuth subnitrate is given.

The Treatment of Fibrinous and Serofibrinous Pleuritis.—LORD (*Boston Med. and Surg. Jour.*, 1909, clx, 469) says that it appears to be established that at least three-fourths of the primary pleuritis with effusion are tuberculous. It is also especially significant, he adds, that out of every ten cases of primary fibrinous or serofibrinous pleurisy, at least three or four develop pulmonary or other tuberculosis within an average period of from four to six years. Therefore, Lord suggests that it seems not too radical that all cases of primary fibrinous and serofibrinous pleurisy, even the mildest forms, in patients otherwise in apparent health, should be treated as if they were tuberculous until they can be proved otherwise. Lord discusses the question of thoracentesis in detail. He has collected a series of 500 cases of serofibrinous effusion, in which sudden death before tapping occurred in three patients. The autopsy showed the cause of death to be pulmonary embolism in two, of whom one had a double effusion, the second a large unilateral accumulation. In the third case, no other cause than pulmonary oedema could be discovered. The frequency with which effusions may be complicated by venous thrombosis also suggested itself to Lord by the occurrence of five cases of pulmonary infarction in a total of fourteen autopsies in this series. He thinks that the removal of fluid and the consequent change in the intrathoracic pressure may dislodge a thrombus and thus cause the infarction. He considers thrombosis with the danger of subsequent embolism and infarction more liable to occur in effusions of long duration, and consequently advocates their early removal. Furthermore, these dangers are increased in double effusions and in large unilateral effusions. Lord also discusses the advisability of tapping medium-sized and small effusions. Many clinicians maintain that a pleural effusion has a conservative function, limiting the respiratory motion on the affected side and thus giving the affected lung the opportunity of spontaneous healing. In addition, the fluid may contain protective substances. Lord says that the clinical evidence supporting these views is in conclusive. However, he believes that the removal of medium-sized and small effusions is not immediately necessary. A short delay may furnish evidence of spontaneous absorption. If this does not occur he advocates tapping. The relief of the pressure alleviates the symptoms, and the course of the disease seems to be shortened. The early removal of the fluid may prevent the formation of venous thrombi and consequent pulmonary infarction. In addition, the danger of pleural adhesions is lessened by early removal. In his series of cases there was less tendency for a re-accumulation of the fluid after early tapping. Lord also mentions the fact that the early removal of fluid excludes the possibility of mistaking an empyema for a serofibrinous effusion. With reference to the amount of fluid to be withdrawn at a single tapping, Lord advises immediate withdrawal of the needle whenever there are any symptoms of distress. These symptoms are usually cough, pain,

or dyspnoea. Usually 1500 c.c. should be the maximum amount withdrawn and more than 2000 c.c. should never be withdrawn. The operation, is usually without any danger in uncomplicated cases in young subjects. In cases of longer duration, however, or those with complicating pulmonary, cardiac, or mediastinal disease, and in patients past middle life, Lord says that the first operation may well be regarded as an experiment. The accidents that may occur are fatal pulmonary or pleural hemorrhages, pulmonary infarction, and pneumothorax. Albuminous expectoration usually results from the removal of too large quantities of fluid, though a few cases have been reported after removal of very small quantities. Lord prefers to use a trocar and cannula with only slight negative pressure exerted by the aspirator. He believes that the cannula is less irritating to the lung and pleura, and in the event of the cannula becoming blocked it may be opened by re-inserting the trocar.

The Employment of Iodopin in Syphilis.—FRESHWATER (*Brit. Med. Jour.*, 1909, i, 1228) gives the technique of the administration of iodopin. Iodopin is prepared by repeated iodization of sesame oil by means of iodine monochloride in alcoholic solution. It is a light oily liquid, and is prepared in two strengths, 10 per cent. and 25 per cent. More recently a solid iodopin has been introduced, and is supplied in yellow-coated tablets of $7\frac{1}{2}$ grains each, corresponding to one grain of potassium iodide. Iodopin may be given by the mouth, or by subcutaneous or intramuscular injection. Freshwater prefers to use the 25 per cent. iodopin, intramuscularly. He gives it in doses of 20 grains, injected daily or every other day. These are given until a total of from 200 to 300 grains of iodopin have been injected. He gives one or two such courses of treatment during a year. No more than six courses of iodopin should be given to the individual patient because of the infiltration of the buttocks resulting from the injections. Freshwater sums up the advantages of iodopin as follows: (1) It is often necessary to give a long course of iodine to patients who are unwilling to take iodide, either because of its depressing effects or because they are the subjects of iodism. (2) All the iodopin injected is used up and must exert its specific action; an exact dosage is, therefore, possible. (3) Injections are painless, and there is no fear of sepsis if proper precautions have been taken. (4) Iodopin subcutaneously does not produce iodism. Patients who have an idiosyncrasy to potassium iodide can take it quite well. (5) Patients remain much longer under the influence of iodine than when iodine is given in other forms. After a short course of injections the system can be kept for a period of four to six months under the influence of iodine. (6) The body is under a slow, continuous, regular action of iodine, which is of prophylactic value. (7) In nearly all cases, after a prolonged course of potassium iodide, there are stomach and bowel troubles. This does not occur with iodopin. (8) It has a specific action in tertiary syphilis and arterial degeneration. Freshwater adds that the disadvantages to the use of iodopin may be briefly summarized as follows: (1) In cases of syphilis, when a rapid therapeutic effect of iodine is required, iodopin is of little use, as the absorption of iodopin is extremely slow, two to ten days elapsing before the iodine can be definitely demonstrated in the urine, so that in cases in which there is a threatened perforation of the